
Taking the Pulse of the U.S. Healthcare Market

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2015 was a significant year for the healthcare insurance market, and more importantly, for the Affordable Care Act (ACA). This paper will examine some of the most important changes in the commercial health insurance market during 2015, using data from the S&P Healthcare Claims Indices. These indices are designed to provide a detailed view of healthcare cost changes at the national, regional, and metropolitan levels. The indices are based on enrollment and paid claims data provided to S&P Dow Jones Indices by 25 health plans collectively covering over 57 million participants. In particular, this paper will examine three critical aspects of the commercial health insurance market.

EXECUTIVE SUMMARY

- This paper looks at the impact of the changes to the individual insurance market from the ACA legislation, both with respect to overall enrollment and the cost of such policies.
- It also investigates cost trends affecting large employers with self-funded medical plans.
- The variations in cost drivers between the individual market and the self-insured market are covered as well.

The changes in the ACA affected costs for both the individual and the group insurance markets during 2014 and 2015.

2015 was essentially the first year in which employers and health plans got a full view of the effects of the ACA changes on their cost structures, and it was a year in which these health plans needed to make key decisions about premiums for 2016. As the S&P Healthcare Claims Indices data indicate, changes in the ACA affected costs for both the individual and the group insurance markets during 2014 and 2015. There are many opinions as to whether passing the ACA has been a benefit or has created more problems and increased costs in the healthcare market. The legislation, which was passed in 2010 by Congress and upheld by the Supreme Court in 2012, contains many features that were intended to simplify the way healthcare works in the U.S. and to reduce the cost of healthcare, but it was primarily intended to ensure that more Americans have healthcare coverage than ever before. The purpose of this paper is neither to endorse the ACA nor to take a position against it, but rather to point out developments, as illustrated by the S&P Healthcare Claims Indices, that exist in the market in the aftermath of the passage of the legislation and other developments in 2015.

2015 marks the first time since the introduction of the legislation that we could truly measure any potential impact on the market. Looking at its history, three key elements of this legislation have had a potential effect on the cost of healthcare in the market.

First, there was a requirement for all individuals to either have healthcare coverage or face tax penalties. The key goal of this part of the legislation was to focus on increasing the number of Americans covered by some form of healthcare.

Second, the legislation extended certain access to coverage options to uninsured individuals with pre-existing health conditions. Under the new law it is now illegal for insurers to refuse to offer coverage due to pre-existing conditions or to terminate a policy of an individual who became ill while covered by an individual policy.

The ACA also extended access to coverage options to uninsured individuals with pre-existing health conditions.

The law also requires that insurers charge the same premium for a healthy individual as one with a pre-existing condition. The expectation was that this pre-existing condition requirement in the legislation would add significant cost to the healthcare market due to the entrance of individuals with pre-existing conditions who were already in need of healthcare. Insurers would not be able to charge premiums that were higher than those allocated to a healthy individual for members with pre-existing conditions. To offset the expected increase in costs, insurers would be subsidized by the government for losses due to these new “unhealthy” members in cases where their estimation of costs was not reflective of the healthiness of the new enrollee pool.

Finally, there was a requirement for health plans to continue covering dependents 26 years of age or younger under their parents’ health coverage. This feature ensures that a select group of people that may have previously gone without health coverage (unless it was provided by a post-secondary institution or employer) would find themselves fully covered. In particular, because this group was younger, they were considered to be lower risk and more healthy. While the expectation was that this requirement would add to total healthcare costs, it would also provide coverage to a healthy population, creating a base for which it could lower the average cost of group insurance plans.

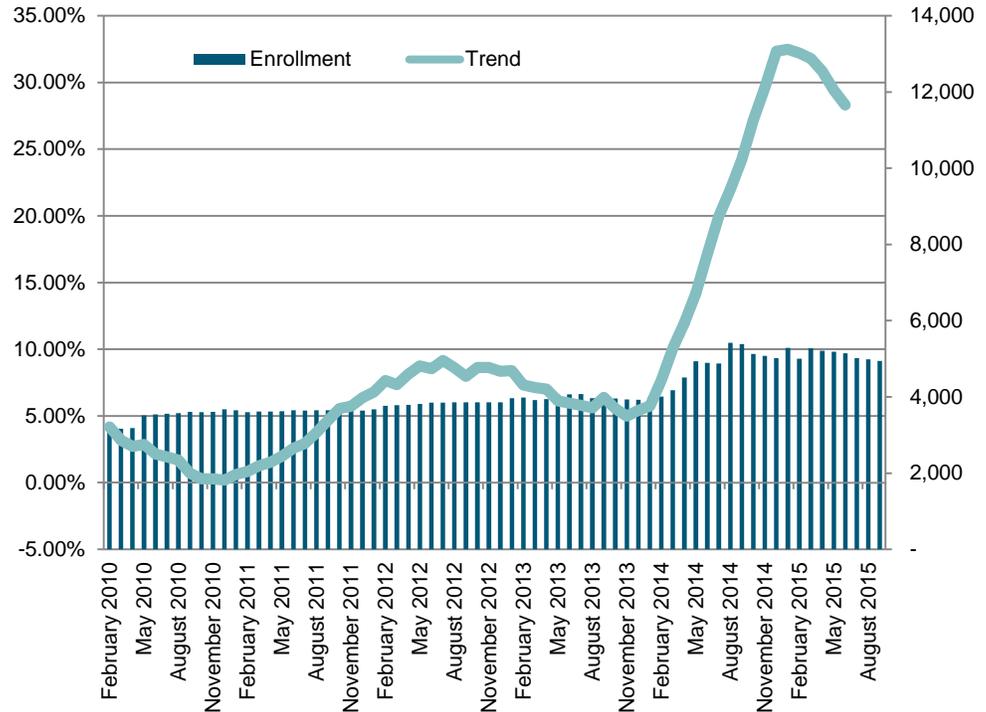
As we look back at 2015, we have data that could potentially start answering the question about whether the ACA achieved its primary goal of ensuring that more Americans have health coverage than ever before.

Enrollment

Because the initial open enrollment in the Health Insurance Marketplace was plagued with administrative problems, growth in enrollment was delayed (see Exhibit 1). In fact, in early 2014, the government announced that open enrollment would be extended to March 31, 2014.

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Exhibit 1: S&P National Individual FFS Medical Total Cost Index Versus Enrollment¹



Source: S&P Dow Jones Indices LLC. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

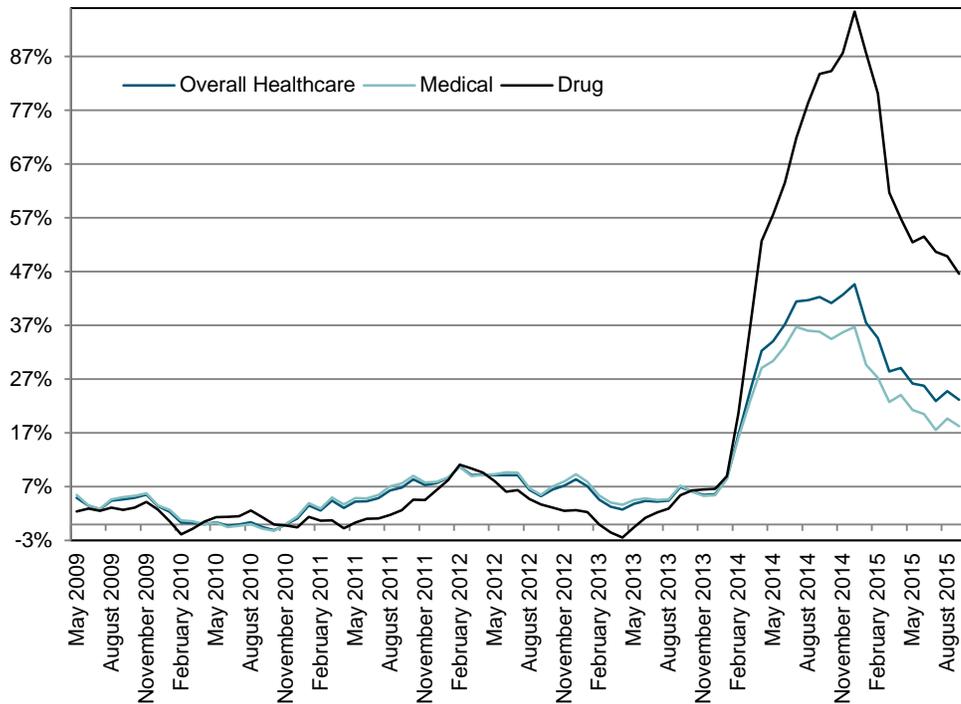
As can be seen in Exhibit 1, individuals started to take advantage of this new coverage, and between October 2013 and September 2015, total enrollment increased over 25% on an adjusted basis, as measured by the S&P Healthcare Claims Indices for the individual market.¹ Given that the S&P Healthcare Claims Indices represent approximately 40% of the total commercial healthcare market in the U.S., we believe that it is reasonable to conclude that the ACA has induced more individuals to elect to buy health coverage.

¹ The enrollment numbers have been adjusted to remove the drop in enrollment due to the removal of a plan from the S&P Healthcare Indices in October 2014.

Cost of Coverage

Looking at the impact of insurers being required to offer insurance to individuals regardless of pre-existing conditions, and at the same cost as an equivalent healthy individual, Exhibit 2 indicates a significant increase in overall costs associated with individual healthcare coverage, as shown by the upward trend in claims costs from Q1 2010 to September 2015.

Exhibit 2: S&P Healthcare Claims National Individual Total Cost Index

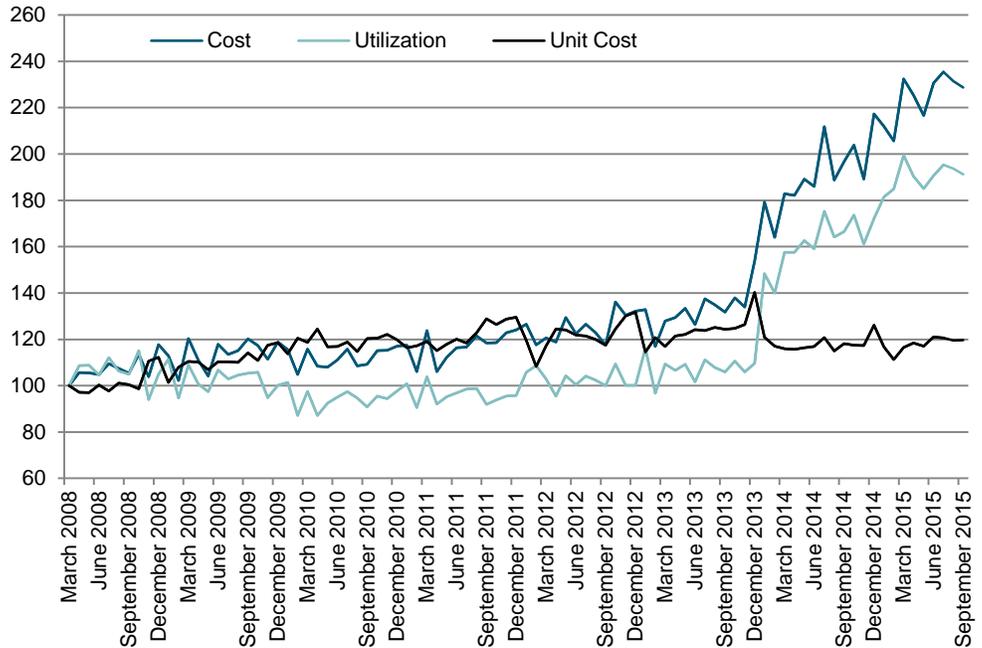


A key question is whether this increase in cost is more associated with an increase in the cost of services, or if it is due to the increase in the utilization of services by the new enrollees post-ACA.

Source: S&P Dow Jones Indices LLC. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

A key question is whether this increase in cost is more associated with an increase in the cost of services, or if it is due to the increase in the utilization of services by the new enrollees post-ACA. To investigate this question, we can look at the utilization of hospital inpatient services. The S&P Healthcare Claims Indices include a utilization measure for hospital inpatient services by tracking the total number of inpatient days per 1,000 people. Exhibit 3 shows the monthly change in the average cost of inpatient services (dark blue line), the average utilization of inpatient services (light blue line), and the average cost per day of inpatient services (black line) as represented by the Index.

Exhibit 3: S&P Healthcare Claims National Individual Hospital Inpatient Index²



Source: S&P Dow Jones Indices LLC. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

Not surprisingly, with the ACA changes in effect, we see a significant increase in overall costs.

As shown in Exhibit 3, prior to January 2014, utilization of inpatient services was fairly stable, with a slight drop from 2008 through 2011 and a slight increase from 2011 to 2013. Starting in January 2014, we begin to see the impact of the ACA on utilization. Not surprisingly, with the ACA changes in effect, we see a significant increase in overall costs. However, the chart shows that not only were overall costs increasing, but the average cost per person was also increasing. What was driving these costs? Was the actual cost of a hospital bed increasing? Looking deeper into the data, we see that the average cost of inpatient services was holding steady. This means that the overall increase in costs for individual coverage was not associated with an increase in the price of inpatient services, but instead it was due to the fact that the utilization of services had increased significantly. This was not unexpected, since a key provision of the ACA was to allow people with pre-existing conditions access to healthcare services. Individuals with serious health conditions have a much higher likelihood of utilizing these services as soon as they have coverage, thus increasing the average cost per person for healthcare services.

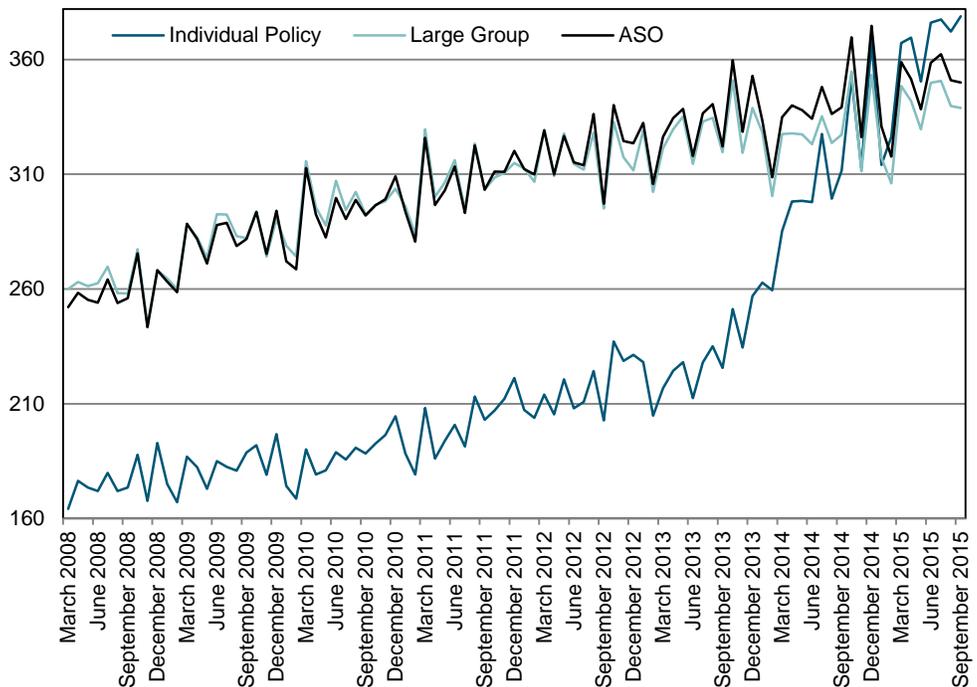
² Due to a change in the way covered days were calculated in 2013 by a number of plans, a significant artificial drop in utilization history not related to market experience is evident in the March 2013 utilization number. Covered days are a key component in the inpatient utilization calculation. For the purposes of this paper, the March 2013 utilization number has been estimated by taking an average of all March and April month utilization changes through history and applying it to March 2013. Only the March 2013 number has been affected by this change.

HAS THE ACA BROUGHT INDIVIDUAL COSTS BACK TO NORMAL?

Healthcare costs between the group insurance (employer) market and the individual market have always been markedly different. Group insurance has always been based on the average cost of the covered group, not the health status of the individual. In fact, during the interview stage, an employer is not permitted to ask any direct questions about a candidate’s health and cannot obtain information through background searches, as all information is protected by the Health Insurance Portability and Accountability Act (HIPAA). In contrast, prior to the introduction of the ACA, individuals seeking health insurance were required to fill out extensive forms related to their health status, and insurers utilized this information to set insurance premium rates and determine whether the individual was insurable. This resulted in a covered group in the individual insured market that was significantly healthier than the equivalent population in the employer market, and thus the first group was less costly as a whole to treat for medical conditions. With the introduction of the ACA and the requirement that insurers offer individual coverage regardless of health status, it would be expected that costs associated with treating the individual market should come in line with the costs associated with the employer market.

Healthcare costs between the group insurance (employer) market and the individual market have always been markedly different.

Exhibit 4: S&P Healthcare Claims National Medical Total Cost PMPM



Source: S&P Dow Jones Indices LLC. ASO: Administrative Services Only. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

As can be seen in Exhibit 4, in the individual line of business (dark blue line), per member per month (PMPM) costs have increased and recently have moved to be more in line with the employer market PMPM costs. Whether costs remain in line with the employer market or continue to escalate will be a critical measure of the ultimate success or failure of the ACA.

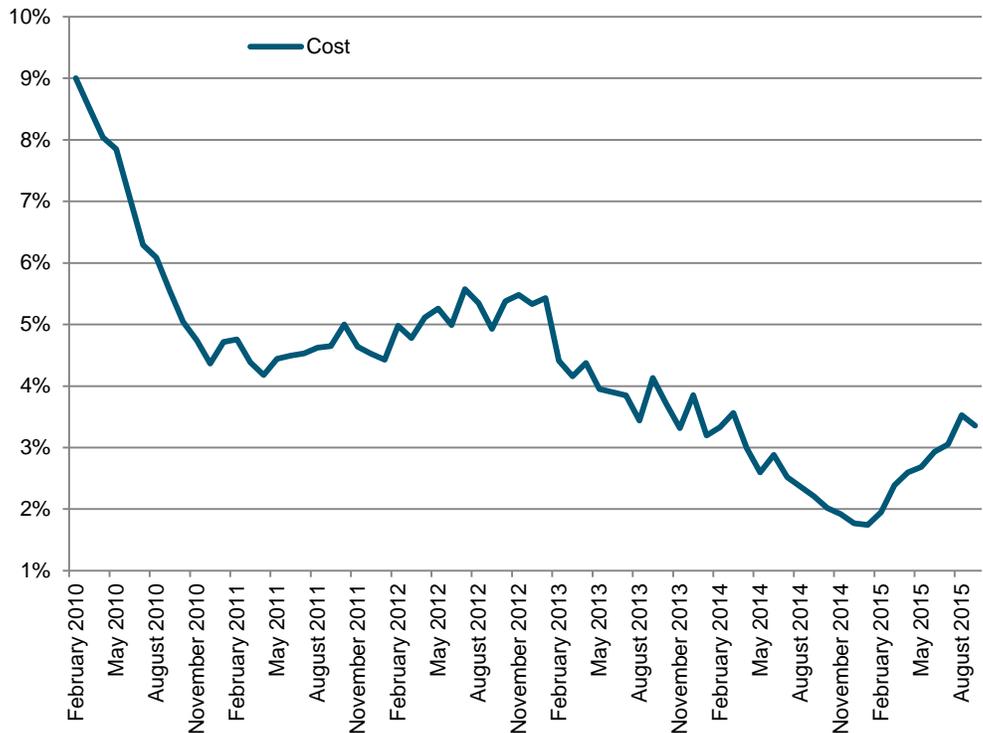
WHAT ABOUT THE EMPLOYER MARKETS?

After several years of declining cost trends, 2015 saw a sharp uptick in overall cost trends associated with medical coverage for the self-insured market (ASO). As seen in Exhibit 5, trends decreased consistently from 2012 through 2014. However, since the start of 2015, they have moved back up to the 3%-to-4% level on a year-over-year basis.

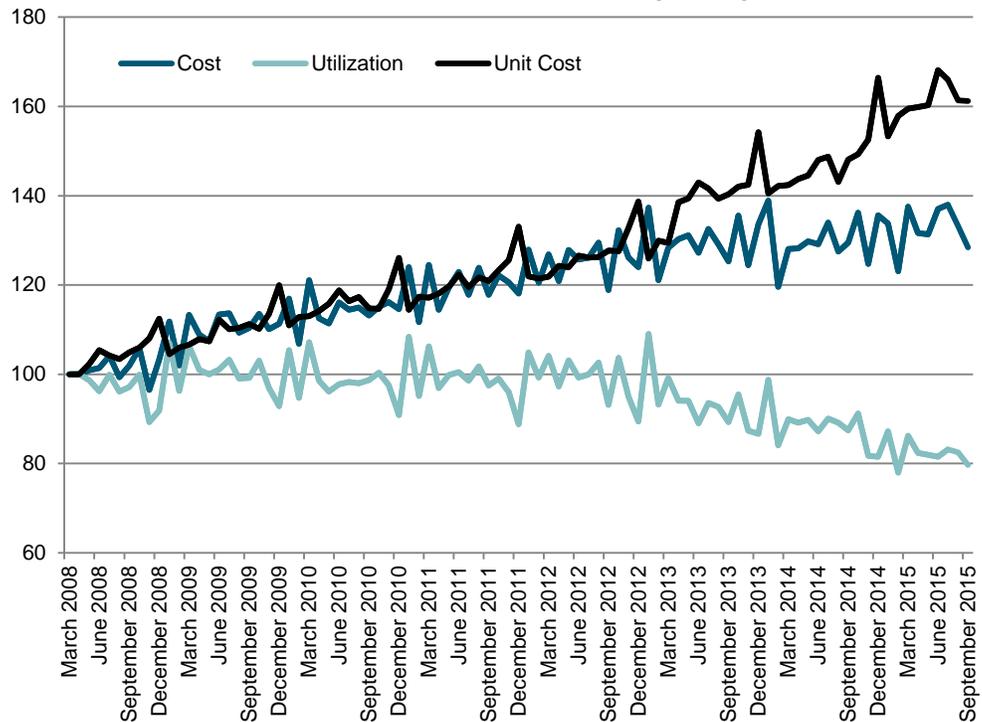
As with the individual market, we can get a better perspective on costs by looking into what factors were driving these changes. As an example, we again turn to hospital inpatient services, where we can look at utilization and unit costs as driving factors.

Whether costs remain in line with the employer market or continue to escalate will be a critical measure of the ultimate success or failure of the ACA.

Exhibit 5: S&P Healthcare Claims National ASO Medical Index



Source: S&P Dow Jones Indices LLC. ASO: Administrative Services Only. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

Exhibit 6: S&P Healthcare Claims National ASO Hospital Inpatient Index

Source: S&P Dow Jones Indices LLC. ASO: Administrative Services Only. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that date are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

The average cost of a hospital bed for employer plans has been steadily increasing since index inception, and it shows no sign of slowing.

Unlike the individual line of business, in which utilization appears to have been driven up by the new enrollees under the protection of the ACA, for self-insured employers, there was no corresponding impact from the ACA, so the overall enrollment remained consistent. As Exhibit 6 shows, overall inpatient utilization has actually been dropping. Since 2013, when key components of the ACA came into play, ASO inpatient costs have increased at a moderate level on a PMPM basis, with the index moving in a corridor between 120 and 140. However, the average cost of a hospital bed for employer plans has been steadily increasing since index inception, and it shows no sign of slowing (see Exhibit 6). Thus the question is why were unit costs rising, while PMPM costs were flat and utilization was dropping? We offer four possible explanations for this.

- It is possible that employers' efforts to try to control healthcare costs were driving these changes. Over the past decade, we have seen employers shifting more costs to employees through higher deductibles, higher co-pays, higher annual minimums, etc. According to a story on CNBC,³ which cited a study from the Kaiser Family Foundation and Health Research & Educational Trust, the average deductible for a

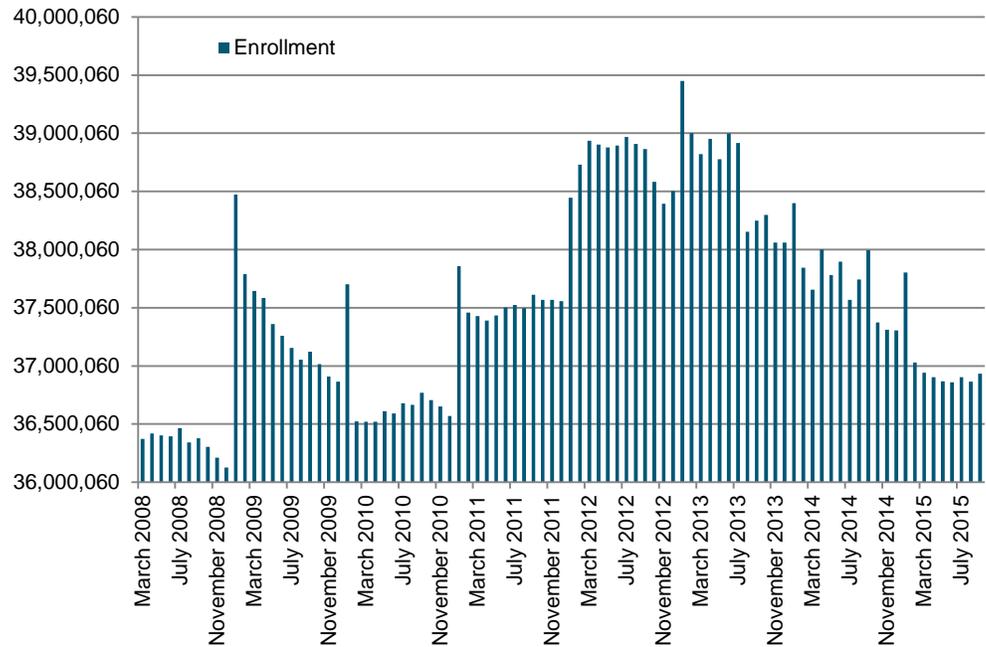
³ ["Employers shifting more health-care costs to employees."](#)

single-coverage plan has increased from USD 303 in 2006 to USD 1,077 in 2015. In addition, according to the same study, 46% of workers with single coverage had a deductible of USD 1,000 or more in 2015, up from just 10% in 2006. With this shift of cost burden to employees, it is likely that employees were utilizing benefits less often, thus decreasing overall utilization. Such a decrease in utilization could mean that service providers could be facing a decrease in overall revenue and would need to push unit cost prices higher in order to meet their revenue targets, thus offsetting some of the cost savings accruing to employers through lower utilization.

- With regard to inpatient services, it may be the case that employer efforts to control inpatient costs resulted in a situation where, over time, the average severity of the conditions treated through inpatient services was increasing, thus increasing the average cost per day for inpatient services. To the extent that this occurred, the conclusion is less that providers were raising their prices and more that employer efforts to control costs were shifting the balance of how people were treated by their health needs.
- It is possible that we were experiencing a shift in the burden of costs from the group insurance (employer) market to the individual market, as coverage through individual policies expands. It is interesting to note that, in Exhibit 6, the decline in utilization for employer plans began in 2013, the year before the ACA individual coverage mandate came into effect. To illustrate this, we would expect to see a drop in enrollment for the ASO group. As illustrated by Exhibit 7, we do see a significant drop in enrollment of about 6.4%. Further, it would be expected that the employers that moved from a self-funded structure to putting employees into the individual mandate would be employers facing the highest costs. If this were the case, it would certainly explain the significant drop in utilization.
- Finally, it is also possible that the changing landscape of the healthcare market was responsible for the decline in utilization. Today more than ever before, an increasing amount of services are being performed in an outpatient setting rather than requiring an overnight hospital stay. Unfortunately, due to limitations in our data available to calculate utilization for other types of services, the S&P Healthcare Claims Indices cannot directly measure the impact of this change on outpatient services.

Today more than ever before, more and more services are being performed in an outpatient setting rather than requiring an overnight hospital stay.

Exhibit 7: S&P Healthcare Claims National ASO Medical Index



Source: S&P Dow Jones Indices LLC. ASO: Administrative Services Only. Back-tested data from February 2008 to September 2015. The S&P Healthcare Indices were launched in October 2013. All data prior to that data are back-tested. Past performance is no guarantee of future results. Chart is provided for illustrative purposes and reflects hypothetical historical performance. Please see the Performance Disclosures at the end of this document for more information regarding the inherent limitations associated with back-tested performance.

We are just starting to see the evolution of the new healthcare market.

CONCLUSION

We are just starting to see the evolution of the new healthcare market. It will still take many years for the issues raised in this paper to be evaluated and for conclusive evidence to provide final answers to the many questions people have about the changes in the healthcare market. In the meantime, utilizing early evidence such as that illustrated by the S&P Healthcare Claims Indices, provides for more input to the continued debate about the merits of the ACA and what the healthcare market will look like 5 or even 10 years from now.

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Another limitation of using back-tested information is that the back-tested calculation is generally prepared with the benefit of hindsight. Back-tested data reflect the application of the index methodology. No hypothetical record can completely account for the impact of financial risk in actual trading. For example, there are numerous factors related to the healthcare market in general which cannot be, and have not been accounted for in the preparation of the index information set forth, all of which can affect actual performance.

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